



Learn More – Module 2

How to Read your Explanation of Benefits

Different insurance companies use different forms, but all EOBs contain the same key information.

Start by checking the basics: information about the member (the primary person enrolled in the plan) and the patient (the person who received services). Have the claim number and your insurance card handy if you have to call with a question

Check the dates of the services you received. The provider is the person or facility that submitted the claim. The service code tells which service was provided. The codes are explained down in a different area. Note: What seems like a single service often involves more than one provider, especially X-rays and lab tests.

Now the dollars and cents: how your claim was processed. The charge is the amount billed by the provider. If a network discount applies, it will be shown here. Then you'll see any other excluded amounts, which the plan does not pay. Excluded amounts could include your deductible, coinsurance or copayments, depending on your plan

Here's an example of a network discount: The doctor charged \$150 minus a \$40 network discount... leaves \$110 as the covered charge.

Then the EOB shows the benefits paid by the plan. The benefit is usually a percentage of the covered charge, like 80%. The insurance company sends the provider a payment for this amount. Most EOBs show an amount called the Estimated Member Responsibility. That's the amount you owe the provider, after the plan benefits are credited to your account.

Be sure to read any notes, explanations and reason codes. These tell why a claim was denied and alert you to any actions you may need to take.